Bear's Ears Child & Family Therapy

Hearing & Healing

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of Bear's Ears Child & Family Therapy Notice of Privacy Practices, which states how my health information may be used and/or disclosed.

_____ Initial

CONSENT FOR TREATMENT

I consent to receive treatment for therapeutic/psychological services through Bear's Ears Child & Family Therapy. If patient is under age 18, parent or legal guardian consents for patient to receive therapeutic/psychological services through Bear's Ears Child & Family Therapy.

_____ Initial

CONSENT AND AUTHORIZATION FOR PAYMENT

I consent to allow billing statement information to be shared with a my designated responsible party for billing, (first and last name)_____. I authorize my insurance company and/or responsible party for billing to make payments directly to Bear's Ears Child & Family Therapy.

_____ Initial

CONSENT TO ALLOW MESSAGES

I consent to allow Bear's Ears Child & Family Therapy to leave appointment or call back messages using the following:

☐ voice mail ☐ text message ☐ email

_____

Print patient name (First, Last)

_____ _____

Patient signature Date

_____

Parent/Legal Guardian name if patient under age 18 (First, Last)

_____ _____

Legal Guardian signature if patient under age 18 Date

_____ _____

Staff signature Date